Satellite Broadcast on Mental Health Courts

Moderator: Could you tell us about some good tests for the detection of malingering?

Dr. Keram: You want to have a sense of what it is the person is presenting that is the actual symptom. So I'll give you some examples. If you have defendant who you may feel is malingering dementia or some type of memory problem, there's a test called the test of malingered memory, the TOMM, in which individuals are shown a series of pictures and asked to remember them for five or ten minutes. Then they are presented with two images, one of which they will have seen before, another which they [haven't], and they'll be asked to pick which one they've seen before. They do this over a series of pictures. If you are faking malingered memory, you will most likely perform worse than chance. Other ways of doing it are looking at personality inventories like the MMPI, where people may overreport their symptoms, so they report every symptom known to man, even symptoms that are placed on that test [to catch] malingerers.

Moderator: Do mental health courts add to the criminalization of the mentally ill?

Judge Dugan: This is a question that has [been used to dog] the mental health courts by various advocate groups, and I think you have to look at it in a different light than they're looking at it. There's a population of the mentally ill that never commit criminal offenses. That's not the population we deal with. We're dealing specifically with the population of the mentally ill that have gotten involved with the criminal justice system because they have committed a crime. Before the advent of mental health courts, that group would have simply gone to jail or state prison, and then come back again because we furnished them no treatment or chance of success. What a mental health court does is actually decriminalize the mentally ill by setting up probation terms and mental health treatment, including medication compliance, that will help them succeed in being on probation and not picking up a new criminal offense and then getting out of the system. So, in fact, we have decriminalized the population.

Moderator: If you determine that you are going to have a drug treatment court, how do you start?

Judge Manley: I think it's a change that comes from judges. And I would hope that that judge would talk to his or her presiding judge first, because without the buy-in of the presiding judge, you're not going to get very far. In terms of putting together a team, I think you're talking about two different things: a team of stakeholders that are going to develop the program, and a team that actually works in the courtroom.

Your key stakeholders, in addition to the presiding judge, are going to be the county executive or the board of supervisors because that is the only place there is any real money that can be redistributed. You're going to need your alcohol and drug director and your mental health director. It is absolutely critical that they both be at the table because you're bringing two fields together that traditionally have not always worked closely together, and you're going to be dealing with dual diagnosis. From the criminal justice side, you must have the district attorney and the public defender, because you're going to be making decisions about who the target population is. You're going to have issues about competency. Finally, it seems to me it's always important to have probation there. I know Pat has had an entirely different experience, particularly relating to another key player, which is the sheriff and the jail.

Pat: The sheriff in our county was instrumental as we began this crusade to initiate a mental health court. It was the sheriff who came to me initially and said, "I've got 16 percent of my jail population diagnosed with serious mental health illness, and a larger percent of females than males. Help me. I'm not a hospital; I'm a jail facility." And so he was a key political actor on that stage of getting the finances arranged so that we could take some of his money as well as some of the money from the county board to put together our program. In addition to the sheriff, you should have the volunteer community. NAMI, the advocates for the mentally ill, are a broad and important coalition to bring to the table because they can bring a lot of pressure on the local politicians at budget time to release those funds necessary to treat this population.

Emcee: Judge Morris, how do you decide who your target population will be?

Judge Morris: Actually, our jails and prisons are so filled, riddled, with the mentally ill that you can start with almost any subset. A lot of drug courts identified early on the dually diagnosed—the mentally ill, drug-abusing population. We began with a negotiation between the DA, the public defender, and the courts. Whom will we allow into this program? In our county, the negotiations ended up with an agreement that we would take primarily nonviolent felons. Most jurisdictions who've started down this road have started with misdemeanor offenses. They've been very cautious, and that's okay.

Emcee: Judge Dugan, I'd certainly like to hear from you about that, as well as the issue of confidentiality, as well as who you think should be at the table if there's anybody who's been left out.

Judge Dugan: I wanted to emphasize to everybody who's trying to do this: You're going to miss some players at the table when you first start, just because you don't always know who you should have had at the table until you've made somebody angry that you didn't have them at the table. Our Mental Health Department in Riverside County, like many county health departments, is broken up into different parts—I referred to it as the octopus of mental health. I would encourage you, when you invite people to the table and expect a lot of meetings, [to] make sure that you have every branch of mental health at your disposal. And the second thing you need at the table is an ability to innovate in the spending of resources. For example, San Francisco just changed how they're going to spend money on their homeless population. The homeless population is largely a mentally ill, dual-diagnosis population, and most of our counties' money can be transferred now if you use a little innovation.

As far as the confidentiality issue, that's the number one issue that [gets] raised by players trying to figure out how to do this. Mental health, particularly, is concerned about confidentiality because they've always been a voluntary system that is required not to tell anybody anything. Of course, with mental health courts that's impossible. We must know exactly how the defendant's doing. Is he medication-compliant? Is he at his treatment program? Etcetera. That puts the clinician in the uncomfortable role of probation clinician, if we can put it that way. We created a confidentiality form. The

public defender's office has that form signed immediately upon the arrival of the defendant into our court, and that form is given to all the players to assure them confidentiality won't be an issue.

Moderator: Judge Morris, there is a question regarding the traditional role of attorneys and judges versus the role that they play in a treatment court.

Judge Morris: What we do in mental health court is not all that different from what we do in drug court. This population is the most challenging imaginable for the judge, for the public defender, for the DA, for the probation officer, for the sheriff's officer. For all who deal with them, we've got to strike a new and more compassionate stance because this population takes the best, requires the most patience, requires the most understanding.

Moderator: The question of funding and resources is one that many people are concerned about. Judge Manley, could you address that?

Judge Manley: Sure. That's a tough question. These are very difficult economic times, as we all know. And I think the biggest mistake you can make is to think that you can apply for a grant and wait five years or two years and get it. That's not going to happen; the money's not there. I think what you have to do is look within. What's really going on is reallocation of money. The clients are there. The mentally ill clients are already in the jail. We are spending a fortune treating them in the jail. The minute we release them, we don't treat them anymore. We assume that they're going to go into voluntary treatment, which they do not do. They're on probation. We spend a fortune monitoring them with no results.

If you want funding for your program, what you have to do, in my view, is sit down with the board of supervisors, the county executive, the head of mental health, the drug and alcohol [people], and reallocate funding for services to the clients you are helping in your program. And the way you justify that, to me, is very straightforward. By keeping these clients out of jail, by cutting down on the recidivism rate, by producing clients that are taking their medications and are staying in treatment, you are saving and avoiding

cost to the county. And in our county we are very blessed, because our board of supervisors understands that and funds the treatment aspect of mental health court entirely with county funds and from nowhere else.

Moderator: Let's talk about what people can expect if they do reallocate resources in that way, and in terms of the recidivism rates.

Judge Manley: Starting out with our mental health court, which has been in existence for over four years, what we have demonstrated by looking at the graduates of the mental health court is a substantial saving in county jail bed days. What we do is take the sentence that was imposed, and we deduct the amount of time the client actually served in jail and multiply times the cost of the bed, and it's amazing that with a very low number of clients you can save over $2 million in a relatively very short time. And I think those numbers alone make economic sense to policymakers[, motivating them] to redirect funding into treatment and away from repeatedly spending it on custody, which costs us more and more every year. I think the recidivism reduction is dramatic.

Moderator: What about in San Bernardino, Judge Morris?

Judge Morris: We looked at the booking rate for a number of felons who were known to be mentally ill. One of the first clients we took in the mental health court was a young man who, in the three years prior to his coming into the mental health court, had had 130 bookings and 3 major episodes that took him to the mental health ward at County Hospital. (Many of our clients are of that history. They show repeated returns to the system.) That young man is now in college and is doing very well. He has not come back to the system. Case after case demonstrates that kind of savings.

Moderator: Do you also treat people with coexisting disorders—that is, substance abuse and mental health issues?

Judge Morris: We have, in fact, found very few of our clients who are seriously mentally ill who do *not* have a co-occurring disorder. The national data shows: 72 to 75

percent of all of those in jail who have serious mental illness also have a drug addiction or an alcohol addiction issue in their life. Our experience is more like 90-plus percent.

Emcee: I assume you have to have a treatment plan to accomplish things like that.

Dr. Keram: The treatment plan really rests on two foundations that have to be solid. One is having an accurate diagnostic assessment, because if you don't get the problem right, you're not going to get the treatment plan right. So, being aware of issues like the prevalence of dual diagnosis is very, very important. The second foundation is that the person who's doing your assessment and the team that's doing the treating have expertise to deal with the problem that's been identified. [But] if you have clinicians who don't have the expertise from the get-go, I wouldn't let that inhibit your initiating the project. What I would recommend is that your clinicians form alliances with their counterparts in counties that do have more expertise and develop a mentoring relationship where they can call for case consultation, and also have that mentor available to recommend books to read and conferences to attend. Once you have a sense of what the diagnosis is or the diagnoses are, a treatment plan is going to involve lots and lots of different pieces. You need to treat the entire environment that this person lives in, making sure that they have a roof over their head in which they're not likely to become noncompliant.

Because this is a concurrent diagnosis population, one of the things that will come up very frequently is: What does a clinician do when they have a defendant who has a severe mental illness but also is actively using substances? Should you go on and treat that mental illness before you address the substance-abusing issue, or do you wait for them to attain some period of sobriety before you do that? And I don't think there is a one-size-fits-all answer to that question. I think a clinician needs to do a very thorough evaluation of that person, because in some situations, if you don't treat the mental illness concurrently, you aren't ever going to get a handle on the chemical dependency issue. Conversely, you may enable chemical dependency use by decreasing mental illness symptoms, and you need to get a sense of who it is that you're dealing with before you go on and make that decision.

Moderator: What keeps coming back is again this issue of resources.

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Judge Dugan: I know that in both Judge Manley's court and in San Bernardino, they've been able to show county jail savings. In Riverside County, we do a lot of very serious violent felons, so they tend to stay in county jail longer periods of time. We can show state prison savings. It's very difficult for us to show jail savings. So, in that sense, the sheriff's office is not always getting the reward, or the county is not always getting the reward. The state is getting the reward. But it's still a matter of reallocation of funds, and there still is a payoff at some end of the system.

Moderator: How do you define success when you're dealing with a mentally ill offender?

Judge Morris: Well, for those of you who have drug court experience, throw away the charts. This is a new and different population, and the definition must be broadened substantially. In drug court, we require employment. We require schooling. We require drug-free living. We require NAs. We require a sponsor. In mental health court, we start with medication compliance. The first thing out of the box is, they've got to be seeing their doctor regularly and taking their meds, and they will, of course, be free from street drugs and alcohol.

But the other definitions of success that we've used in drug court do not necessarily apply here. A substantial number of these folks are so low functioning that you have to reduce your level of expectations. Many are illiterate, and when you say, "Go to school," you may mean simply “Go the county library and be engaged in a literacy program.” What you want to do is essentially find a way to occupy them constructively in the community. Re-engage them with their family if at all possible, or a semblance of family, so that they have a support group out there and a daily activity to go to that’s meaningful and constructive. And it may be as simple as a volunteer position at a homeless shelter; it may be at a school; but you look for a variety of ways to simply help them reconstruct a life that has some meaning to it, and that's about all you can do with some of these clients.

Dr. Keram: It really requires that the treatment team adequately first assess and then fully accept the client's potential capacity so that we don't form expectations that exceed this person's capacity when they're maximally functioning. That will decrease the frustration level of the treatment team.

Judge Manley: I think the real problem is that you never want to make their life more complex than it already is, and I never ask a client to do more than three things. It's usually only one. I think [with] some clients you have to start out with the expectation [that] they come to the court, [that] they learn the bus route. That's enough to begin with. They've never done any of these things before. And the key to me is not what these goals are that you set, but rewards and applause and support for each and every accomplishment they make.

Moderator: What happens when someone is sent to the state hospital because they are mentally incompetent to participate in the proceedings—basically a 1368 type of client? They receive treatment in the state hospital. They're medicated. They come back to the county jail with their competency apparently restored. But in the county jail they refuse to take their medication. The question arises when the jail psychiatric or psychological staff refuse to insist or force them to take the medication; they decompensate and are no longer competent to participate in the proceedings. Dr. Keram, would you explain why a doctor would do that in a jail? And then we'll have the judges respond to what they do when they're confronted with such a problem.

Dr. Keram: People who are incarcerated don't lose their civil rights, and a patient who's returned from having their competency restored who refuses medication may or may not be competent to make the decision to refuse medication. So the physician is not going to want to involuntarily medicate that person without respecting their due process, and that involves having a release hearing to determine whether the person's competent to participate in the medical decision making. Before that ever happens, there's lots and lots of things that can be done. The most obvious question that I would think of first is: Why did the person stop their medication? Were their pills yellow at Atascadero because of the generic brand they were taking, and they're blue in San Francisco, and

so they don't think it's the same medication and they're suspicious about it? So the first thing is to identify what the problem is and see if you can address it on that level.

Moderator: Okay. And then from the judges, what do you do when you're confronted with that kind of problem?

Judge Dugan: It's my experience that most of the defendants returning in Southern California [come from] Patton, and I think in Northern California it's Atascadero. When they're returning in an either competent or quasicompetent way, generally it's a gap in the entry into the jail and [in] the awareness [at] the jail of what medication they're on that causes the decompensation, because most of those defendants at the time they enter the jail, they've been on meds, and they're med-compliant. They're not refusing. Once they start missing a day or two even of their medication, now they're going back to their mental illness, and they begin to refuse. So education and training of the jail staff has been our chief way to stop that cycle. The jail staff knows now that they are to immediately tag those defendants that are received from Patton, get them to the psychiatrist or the jail nurse immediately.

Moderator: What about personality disorders, Judge Morris? Do you handle people with personality disorders in your mental health treatment court?

Judge Morris: You're talking about Axis II folks. No, we don't. That's a disqualifier in our mental health court. We work with folks with an Axis I diagnosis for reasons that the doctor will explain.

Dr. Keram: I'm not sure that there is a hard-and-fast rule in every mental health court that they would not see Axis II clients. In a situation in which you have limited resources and such a great need, you may try to develop selection criteria that will maximize the chance that you're going to get a good fit between the court and the client. And people with personality disorders (Axis II diagnoses, is a way your mental health commissioners refer to it) tend to not take responsibility for their behavior and to project that responsibility or blame onto other people, and that may make them a poor candidate for

mental health court. However, they may also respond very, very well to structure and limit setting, and in that way they may be good candidates. Judge Dugan is nodding. It would be interesting to hear what her experience is with that particular diagnosis.

Judge Dugan: This goes to what you want [as] your target population. When we set up our court—and I think Judge Manley set his court up the same way—we took everybody, even people that were initially screened as just drug addicts, because sometimes once you get past the drug addiction, you see the mental illness. Axis II diagnosis, as our clinicians say, is a very difficult group. They're very narcissistic as a group. They project blame, and if you want to define a target population, it's much easier for a court and for staff not to take them. We took them just because we don't want to make limits, and the statistics—and I think the doctor can correct me—are overwhelming that your group most likely to be recidivists are Axis II. Would you agree with that?

Dr. Keram: I don't know that data, so—

Judge Dugan: That's the data I've seen. I don't think that means we shouldn't take them, though, because you can move them, and you can get them improved, and you can get them functioning. In my court the goal was no new criminal behavior, because I believe that just because a person has a mental illness doesn't excuse [his] stealing from Circle K. The Axis II folks, although they're difficult to deal with, can learn not to have criminal behavior.

Judge Manley: I think it's a hard group to take. I wouldn't advise anyone starting out to take them. We take them for the very reason Judge Dugan mentioned, related to their continued criminal activity and that you can effect change. With this group of individuals, sanctions do work. They do respond. So do custody programs, highly structured custody programs. They will perform very well and meet expectations you never thought they would.

Dr. Keram: What you want to do is really evaluate how well this person in the past has responded to limit setting.

Moderator: How about you, Judge Morris?

Judge Morris: There's an external force alive and well in the community, and we need to use that to help us maintain this program: it's the power of the press; it's the power of the community spirit. And those of us who do this often go out in the community and talk to Rotarians, etc., and we spread the word, and that word often makes its way to the editorial boards of our newspapers. And we have seen marvelous support from editorial boards and the press in general about this outreach effort by the court. We are, for the first time in memory, not simply processing cases; we're doing the right thing in helping people solve the base issues that bring them into the criminal justice system.